Exhibit 12a

The City of New York

MEDICAL REQUEST FOR HOME CARE

Human Resources Administration
Home Care Services Program
Form M-11q (Page 1)
03/02

RETURN COMPLETED FORM TO: GSS District Office 7 Attn.: Case Load No. K12C3 ✓
Address 2865 W 8th St. 2nd Floor BROOKLYN, NY Boro__
Zip Code_ Tel. No. (718) 265-5512

Date Returned to/Received by GSS
MAY 10 2005
FOR GSS USE ONLY

I. CLIENT INFORMATION

PATIENT'S NAME	BIRTHDATE	SOCIAL SECURITY NUMBER	MEDICAID NO.
Client # 082506		[redacted]	[redacted]

HOME ADDRESS (No. & Street)	BORO	ZIP CODE	TELEPHONE NO.
[redacted]	[redacted]	[redacted]	[redacted]

Hospital/Clinic Chart No.	Contact Person	Contact Tel. No.
	[redacted]	

II. MEDICAL STATUS

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA/ Dept. of Social Services in connection with my request for home care.

DATE:_ SIGNATURE(X) _____

How long have you treated the patient? 12/29/99 Date of this examination: 4/19/05 Place of this examination: office Date of next examination: _____

A. CURRENT CONDITION

DATE OF ONSET		Check (✓) prognosis of each	Anticipated Recovery in 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
	1. PRIMARY DIAGNOSIS	Macular degeneration, Type 2 diabetes			
	2. SECONDARY DIAGNOSIS	Hyperlipidemia			
	3.	Atherosclerosis			
	4.	Chronic simplex, Arthritis			
	5.	s/p ⓒ Lip Ex.			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN: (Hospital Name) _____ ADMISSION DATE: _____

Reason for HOSPITALIZATION: _____ EXPECTED DATE OF DISCHARGE:

C. MEDICATION

		DOSAGE	ORAL or PARENTERAL	FREQUENCY
1.	Travatan	40 γ	ro	QD
2.	ASA	81 γ tc	ro	QD
3.	Tylenol	1 γ	ro	prn
4.				
5.				
6.				
7.				

INDICATE PATIENT'S ABILITY TO TAKE MEDICATION: (*)

1. ☐ can self-administer
2. ☑ needs reminding
3. ☑ needs supervision
4. ☑ needs help with preparation
5. ☑ needs administration

(*) If patient CANNOT self-administer medication

(a) can he/she be trained to self-administer medication? ☐ Yes ☑ No If No, indicate why not: For Macular degeneration

(b) What arrangements have been made for the administration of medications? Son is aware

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SSN: [redacted]
Form M-[illegible]
03/02

D. IMPAIRMENTS — Does the patient have any of the following impairments? ☑ Yes ☐ No
If there is an impairment, indicate by check (✓) type and degree of impairment:

SENSORY IMPAIRMENT	PARTIAL	TOTAL
1. Speech	☐	☐
2. Sight	☐	☑
3. Hearing	☑	☐

MUSCULAR/MOTOR IMPAIRMENT	PARTIAL	TOTAL
1. Dominant hand/arm	☐	☐
2. Other hand/arm	☐	☐
3. Muscular Coordination	☐	☐
Upper Extremities	☐	☐
Lower Extremities	☑	☐

CARDIOVASCULAR/RESPIRATORY IMPAIRMENT	PARTIAL	TOTAL
1. Respiratory function	☐	☐
2. Cardiac function	☐	☐
3. Circulation	☑	☐

ELIMINATION (Check ✓)

	Continent	Occasionally Incontinent	Incontinent
Bladder	✓		
Bowel	✓		

Indicate reason for incontinence and what is currently being done: _____

E. MENTAL STATUS - Does the patient exhibit any of the following? ☐ Yes ☐ No If Yes, check appropriate boxes.

	Some-times	Always		Some-times	Always		Some-times	Always		Some-times	Always
1. Disoriented to place/time	☐	☐	4. Short-term memory impairment	☐	☐	7. Impaired judgment	☑	☐	10. Communication problems	☐	☐
2. Anxiety	☑	☐	5. Wandering	☐	☐	8. Danger to others	☐	☐	11. Sleep Disorder	☐	☐
3. Agitation	☑	☐	6. Depression	☑	☐	9. Danger to self	☑	☐	12. Abusive	☐	☐

Describe the nature, frequency and effect on client's functioning for any area checked.
Attach additional documentation if necessary.
At times help she is capable of more than she can really do and does not accept her disabilities, especially her sight. As Result, she can be in danger if no help at times

Is patient alert? ☑ Always ☐ Sometimes ☐ Never

Can patient direct a home care worker? ☑ Yes ☐ No If No, explain below.

F. MEDICAL TREATMENT — Does the patient need any of the following medical treatment? ☐ Yes ☐ No
Indicate medical treatment needed: (✓)

1. Decubitus Care		7. Colostomy care		15. Suctioning	
2. Dressings: Sterile / Simple		8. Ostomy care		16. Speech/hearing therapy	
3. Bed bound care (turning, exercising, positioning)		9. Oxygen administration		17. Occupational therapy	
4. Ambulation exercise		10. Catheter care		18. Rehabilitation therapy	
5. ROM/Therapeutic exercise		11. Tube irrigation		19. Indicate any special dietary needs	
6. Enema		12. Monitor vital signs		20. Other	
		13. Tube feeding			
		14. Inhalation therapy			

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

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G. EQUIPMENT/SUPPLIES

SSN: [redacted]
Form M-11q (Page 3)
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Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered
Cane	✓		
Crutches			
Walker			
Wheelchair			
Hospital Bed			
Side Rails			

	Has	Needs	Ordered
Bedpan/Urinal			
Commode			
Diapers			
Hoyer Lift			
Dressings			
Respiratory Aids			

	Has	Needs	Ordered
Bath Bar			
Bath Seat			
Grab Bar			
Shower Handle			
Other (Specify)			

If any needed equipment was not ordered, what other plans have been made to meet this need?

III. IDENTIFICATION OF SERVICE NEEDS

A. Indicate ability to ambulate/transfer:

	Can	Cannot	Can with assistance of:				
			Cane	Walker	Person	Other:	(Specify)
1. Ambulate inside					✓		
2. Ambulate outside					✓		
3. Get up from seated position					✓		
4. Get up from bed					✓		
5. Transfer to commode							
6. Transfer to wheelchair							

B. Indicate any services needed (✓)

A. CHORE SERVICES:

- ✓ Cleaning
- ✓ Meal Prep
- ✓ Laundry
- ✓ Shopping
- ✓ Reheat Meals

B. PERSONAL CARE SERVICES:

	Partial	Total
1. Grooming		✓
2. Dressing		✓
3. Washing		✓
4. Bathing		✓

	Partial	Total
5. Feeding	✓	
6. Toileting: Bedpan		
Commode		

7. Other special toilet needs:

IV. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? ☐ Yes * ☑ No

* Identify AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

PHYSICIAN'S CERTIFICATION

I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and that I may be contacted for further clarification.

(PRINT) Physician's Name	Specialty	Physician's Signature	
Robert Mond, M.D.	Internal Medicine	[signature]	☐ Intern ☐ Resident

Date Form Completed	Registry No.	Telephone No.	Hospital Contact Person	Telephone No.
4/19/05	116720	718-435-6555		

Indicate where form was completed:

Hospital/Clinic/Inst. Name	Address	Telephone No.

If nurse/social worker/other person assisted in completing this form:

Name	Title	Address	Telephone No.

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SSN [redacted]
Form [illegible]
03/02

V. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care.

pt is legally blind due to [illegible]

pt [illegible]

pt is unable to prepare own meals, due to [illegible] in using stove due to blindness

pt is fragile and requires F/T help

Signature of Person Completing Additional Comments Section	Title	Date
[signature]		4 19
	Agency	

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The City of New York
Office of Home Care Services

MEDICAL REQUEST FOR HOME CARE

FORM M-11q(Page1)
Rev. 3/84

RETURN COMPLETED FORM TO: GSS District Office # _____ Attn: Caseload No. K10 C3 Address _____ Boro _____ ZIP Code _____ Tel. No. _____

CASA VII INTAKE

Date Returned to/Received by GSS
2006 JUN 13 A 11:34
FOR GSS USE ONLY

I. CLIENT INFORMATION

PATIENT'S NAME	BIRTHDATE	SOCIAL SECURITY NUMBER	MEDICAID NO.
Client # 082506	[redacted]	[redacted]	[redacted]
HOME ADDRESS(No. & Street)	BORO / ZIP CODE		TELEPHONE NO.
[redacted]	[redacted]		[redacted]
Hospital/Clinic Chart No.	Contact Person		Contact Tel. No.
	[redacted]		[redacted]

II. MEDICAL STATUS

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination or treatment to the New York City HRA/Dept. of Social Services in connection with my request for home care.

DATE: _____ SIGNATURE(X) _____

How long have you treated the patient? 12/29/79 Date of this examination: 5/18/06 Place of this examination: office Date of next examination: _____

A. CURRENT CONDITION

DATE OF ONSET		Check (✓) prognosis of each	Anticipated Recovery in 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
	1. PRIMARY DIAGNOSIS	Macular degeneration, Arteriosclerosis			
	2. SECONDARY DIAGNOSIS	OVT-(R) Leg x 4 weeks			
	3.	Type 2 diabetes, hyperlipidemia			
	4.	Venous insufficiency, Arthritis, S/P (R) hip fx			
	5.	Abdominal hernia, Right Med Rotator cuff			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN: (Hospital Name) _____ ADMISSION DATE: _____

REASON FOR HOSPITALIZATION: _____ EXPECTED DATE OF DISCHARGE:

C. MEDICATION

		DOSAGE	ORAL or PARENTERAL	FREQUENCY
1.	Pepcid	20mg	po	daily
2.	Zocor	10mg	po	daily
3.	Colace	100mg	po	TID
4.	Tylenol	325mg	2 tabs po	q 6h prn
5.	Coumadin	1mg	3 tabs po	daily except SAT
6.				
7.				

INDICATE PATIENT'S ABILITY TO TAKE MEDICATION: (*)

1. ☐ can self-administer?
2. ☐ needs reminding
3. ☐ needs supervision
4. ☐ needs help with preparation
5. ☑ needs administration

(*) If patient CANNOT self-administer medication:

(a) can he/she be trained to self-administer medication? ☐ Yes ☑ No If No, indicate why not: Pt. has macular degeneration & arteriosclerosis

(b) What arrangements have been made for the administration of medications? Son is aware

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D. IMPAIRMENTS – Does the patient have any of the following impairments? ☐ Yes ☐ No
If there is an impairment, indicate by check (✓) type and degree of impairment:

SENSORY IMPAIRMENT	PARTIAL	TOTAL
1. Speech	☐	☐
2. Sight	☐	✓
3. Hearing	✓	☐

MUSCULAR/MOTOR IMPAIRMENT	PARTIAL	TOTAL
1. Dominant hand/arm	☐	☐
2. Other hand/arm	☐	☐
3. Muscular Coordination	☐	☐
Upper Extremities	☐	✓
Lower Extremities	✓	☐

CARDIOVASCULAR/RESPIRATORY IMPAIRMENT	TOTAL
1. Respiratory function	☐
2. Cardiac function	☐
3. Circulation	☐

ELIMINATION (Check ✓)

	Continent	Occasionally Incontinent	Incontinent
Bladder	✓		
Bowel	✓		

Indicate reason for incontinence and what is currently being done:

E. MENTAL STATUS –Does the patient exhibit any of the following? ☐ Yes ☐ No If Yes, check appropriate boxes.

	Sometimes	Always
1. Disoriented to place/time	✓	☐
2. Anxiety	✓	☐
3. Agitation	✓	☐
4. Short-term memory impairment	✓	☐
5. Wandering	☐	☐
6. Depression	✓	☐
7. Impaired judgement	✓	☐
8. Danger to others	☐	☐
9. Danger to self	✓	☐
10. Communication problems	☐	☐
11. Sleep Disorder	☐	☐
12. Abusive	☐	☐

Describe the nature, frequency and effect on client's functioning for any area checked.
Attach additional documentation if necessary.

Pt. has had episodes of poor memory & disorientation. She has manic depression & has been anxious & depressed because of her disabilities. Tries to do more than she is capable of. As much she can be a danger to herself at times.

Is patient alert? ✓ Always ☐ Sometimes ☐ Never

Can patient direct a home care worker? ✓ Yes ☐ No If No, explain below.

F. MEDICAL TREATMENT – Does the patient need any of the following medical treatment? ☐ Yes ☐ No
Indicate medical treatment needed: (✓)

1. Decubitus care		7. Colostomy care		15. Suctioning	
2. Dressings: Sterile / Simple		8. Ostomy care		16. Speech/hearing therapy	
3. Bedbound care (turning, exercising, positioning)		9. Oxygen administration		17. Occupational therapy	
4. Ambulation exercise		10. Catheter care		18. Rehabilitation therapy	
5. ROM/Therapeutic exercise		11. Tube irrigation		19. Indicate any special dietary needs	
6. Enema		12. Monitor vital signs		20. Other	
		13. Tube feeding			
		14. Inhalation therapy			

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

G. EQUIPMENT/SUPPLIES

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Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered
Cane	✓		
Crutches			
Walker			
Wheelchair			
Hospital Bed			
Side Rails			

	Has	Needs	Ordered
Bedpan/Urinal			
Commode			
Diapers			
Hoyer Lift			
Dressings			
Respiratory Aids			

	Has	Needs	Ordered
Bath Bar			
Bath Seat			
Grab Bar			
Shower Handle			
Other(Specify)			

If any needed equipment was not ordered, what other plans have been made to meet this need?

III. IDENTIFICATION OF SERVICE NEEDS

A. Indicate ability to ambulate/transfer:

	Can	Cannot	Can with assistance of: Cane	Walker	Person	Other:	(Specify)
1. ambulate inside					✓		
2. ambulate outside					✓		
3. Get up from seated position					✓		
4. Get up from bed					✓		
5. Transfer to commode							
6. Transfer to wheelchair							

B. Indicate any services needed (✓):

A. CHORE SERVICES:

- ☑ Cleaning
- ☑ Meal Prep
- ☑ Laundry
- ☑ Shopping
- ☑ Reheat Meals

B. PERSONAL CARE SERVICES:

	Partial	Total
1. Grooming	☑	
2. Dressing	☑	
3. Washing	☑	
4. Bathing		☑
5. Feeding	☑	
6. Toileting: Bedpan		
Commode		
7. Other special toilet needs:		

IV. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? ☐ Yes * ☐ No

* Identify AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

PHYSICIAN'S CERTIFICATION

I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and that I may be contacted for further clarification.

ROBERT MANN — (PRINT)Physician's Name
MD. MED — Specialty
[signature] — Physician's Signature
☐ Intern ☐ Resident

6/14/06 — Date Form Completed
11620 — Registry No.
718-435-8555 — Telephone No.
Hospital Contact person
Telephone No.

Indicate where form was completed:

Hospital/Clinic/Inst. Name — Address — Telephone No.

If nurse/social worker/other person assisted in completing this form:

Name — Title — Address — Telephone No.

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V. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care.

Patient has chronic DVT. Patient is legally blind (macular degeneration) which has gotten worse

Patient is 98 years old and has dementia. Patient is 98 years old and needs assistance getting in and out of bed and walking to and from the bathroom.

Patient needs to have 24 hour by 7 day care to avoid falls, to assure patient where she is and provide for her toiletting needs.

Signature of Person Completing Additional Comments Section	Title	Date 6/8/06
	Agency	

The City of New York

The City of New York
Office of Home Care Services

MEDICAL REQUEST FOR HOME CARE

FORM M-11q(Page 1)
Rev. 3/84

C3

RETURN COMPLETED FORM TO: GSS District Office # ______ Attn: Caseload No. ______
Address ______ Boro ______
ZIP Code ______ Tel. No. ______

Date Returned to/Received by GSS

FOR GSS USE ONLY

I. CLIENT INFORMATION

PATIENT'S NAME	BIRTHDATE	SOCIAL SECURITY NUMBER	MEDICAID NO.
Client # 082506	[redacted]	[redacted]	[redacted]

HOME ADDRESS (No. & Street)	BORO	ZIP CODE	TELEPHONE NO.
[redacted]	[redacted]	[redacted]	[redacted]

Hospital/Clinic Chart No.	Contact Person	Contact Tel. No.
	[redacted]	[redacted]

II. MEDICAL STATUS

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination or treatment to the New York City HRA/Dept. of Social Services in connection with my request for home care.

DATE: ______ SIGNATURE (X) ______

How long have you treated the patient? 12/29/79 Date of this examination: 5/7/07 Place of this examination: office Date of next examination: ______

A. CURRENT CONDITION

Check (✓) prognosis of each

DATE OF ONSET			Anticipated Recovery in 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
	1. PRIMARY DIAGNOSIS	Dementia, arteriosclerosis, macular degeneration			
	2. SECONDARY DIAGNOSIS	Type 2 diabetes			
	3.	Hyperlipidemia			
	4.	Venous insufficiency, Arthritis			
	5.	Abdominal hernia			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN: (Hospital Name) ______ ADMISSION DATE: ______

REASON FOR HOSPITALIZATION: ______

EXPECTED DATE OF DISCHARGE:

C. MEDICATION

	DOSAGE	ORAL or PARENTERAL	FREQUENCY
1. Zocor	10mg	po	daily
2. ASA	81mg ec	po	daily
3. Toprol XL	50mg	po	daily
4.			
5.			
6.			
7.			

INDICATE PATIENT'S ABILITY TO TAKE MEDICATION: (*)

1. ☐ can self-administer?
2. ☐ needs reminding
3. ☐ needs supervision
4. ☐ needs help with preparation
5. ☒ needs administration

(*) If patient CANNOT self-administer medication:

(a) Can he/she be trained to self-administer medication? ☐ Yes ☒ No If No, indicate why not: Has dementia & macular degeneration

(b) What arrangements have been made for the administration of medications? Son is doing

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p-v. 3/84

D. IMPAIRMENTS – Does the patient have any of the following impairments? ☐ Yes ☐ No
If there is an impairment, indicate by check (✓) type and degree of impairment:

SENSORY IMPAIRMENT	PARTIAL	TOTAL
1. Speech	☐	☐
2. Sight	☐	☑
3. Hearing	☑	☐

MUSCULAR/MOTOR IMPAIRMENT	PARTIAL	TOTAL
1. Dominant hand/arm	☐	☐
2. Other hand/arm	☐	☐
3. Muscular Coordination	☐	☐
Upper Extremities	☐	☐
Lower Extremities	☑	☐

CARDIOVASCULAR/RESPIRATORY IMPAIRMENT	TOTAL
1. Respiratory function	☐
2. Cardiac function	☐
3. Circulation	☐

ELIMINATION (Check ✓)

	Continent	Occasionally Incontinent	Incontinent
Bladder		✓	
Bowel		✓	

Indicate reason for incontinence and what is currently being done:

E. MENTAL STATUS –Does the patient exhibit any of the following? ☑ Yes ☐ No If Yes, check appropriate boxes.

	Sometimes	Always
1. Disoriented to place/time	☑	☐
2. Anxiety	☑	☐
3. Agitation	☑	☐
4. Short-term memory impairment	☐	☑
5. Wandering	☐	☐
6. Depression	☑	☐
7. Impaired judgement	☑	☐
8. Danger to others	☐	☐
9. Danger to self	☑	☐
10. Communication problems	☐	☐
11. Sleep Disorder	☐	☐
12. Abusive	☐	☐

Describe the nature, frequency and effect on client's functioning for any area checked.
Attach additional documentation if necessary.

Has had episodes of poor memory & disorientation. Has dementia + macular degeneration. As such can be danger to herself

Is patient alert? ☑ Always ☐ Sometimes ☐ Never

Can patient direct a home care worker? ☑ Yes ☑ No If No, explain below. Patient has dementia

F. MEDICAL TREATMENT – Does the patient need any of the following medical treatment? ☐ Yes ☐ No
Indicate medical treatment needed: (✓)

1. Decubitus care		7. Colostomy care		15. Suctioning	
2. Dressings: Sterile / Simple		8. Ostomy care		16. Speech/hearing therapy	
3. Bedbound care (turning, exercising, positioning)		9. Oxygen administration		17. Occupational therapy	
4. Ambulation exercise		10. Catheter care		18. Rehabilitation therapy	
5. ROM/Therapeutic exercise		11. Tube irrigation		19. Indicate any special dietary needs	
6. Enema		12. Monitor vital signs		20. Other	
		13. Tube feeding			
		14. Inhalation therapy			

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

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D03720

G. EQUIPMENT/SUPPLIES

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Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered		Has	Needs	Ordered		Has	Needs	Ordered
Cane	✓			Bedpan/Urinal				Bath Bar			
Crutches				Commode				Bath Seat			
Walker				Diapers				Grab Bar			
Wheelchair				Hoyer Lift				Shower Handle			
Hospital Bed				Dressings				Other(Specify)			
Side Rails				Respiratory Aids							

If any needed equipment was not ordered, what other plans have been made to meet this need?

III. IDENTIFICATION OF SERVICE NEEDS

A. Indicate ability to ambulate/transfer:

	Can	Cannot	Can with assistance of: Cane	Walker	Person	Other:	(Specify)
1. ambulate inside					✓		
2. ambulate outside					✓		
3. Get up from seated position					✓		
4. Get up from bed					✓		
5. Transfer to commode					✓		
6. Transfer to wheelchair							

B. Indicate any services needed (✓):

A. CHORE SERVICES:

- ☐ Cleaning
- ☐ Meal Prep
- ☐ Laundry
- ☐ Shopping
- ☐ Reheat Meals

B. PERSONAL CARE SERVICES:

	Partial	Total
1. Grooming	☐	☐
2. Dressing	☐	☐
3. Washing	☐	☐
4. Bathing	☐	☐
5. Feeding	☐	☐
6. Toileting: Bedpan	☐	☐
Commode	☐	☐
7. Other special toilet needs:		

IV. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? ☐ Yes * ☐ No

* Identify AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

PHYSICIAN'S CERTIFICATION

I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and that I may be contacted for further clarification.

ROBERT MANN — (PRINT)Physician's Name

INTERNAL MEDICINE — Specialty

Physician's Signature

☐ Intern ☐ Resident

5/5/03 — Date Form Completed

116720 — Registry No.

718-435-6055 — Telephone No.

Hospital Contact person

Telephone No.

Indicate where form was completed:

Hospital/Clinic/Inst. Name

Address

Telephone No.

If nurse/social worker/other person assisted in completing this form:

Name

Title

Address

Telephone No.

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V. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care.

Patient has chronic DVT. Patient is legally blind (macular degeneration) which has gotten worse

Patient is 98 years old and has dementia. Patient is 99 years old and needs assistance getting in and out of bed and walking to and from the bathroom.

Patient needs to have 24 hour by 7 day care to avoid falls, to assure patient where she is and provide for her toiletting needs.

Signature of Person Completing Additional Comments Section	Title	Date
	Agency	

The City of New York

MEDICAL REQUEST FOR HOME CARE

Human Resources Administration
Home Care Services Program
Form M-11q (Page 1)
03/02

RETURN COMPLETED FORM TO: GSS District Office 7 Attn.: Case Load No. K12A4
Address 2865 W 8th St. 2nd Floor BROOKLYN, NY 11224-3604 Boro
Zip Code Tel. No. (718) 265-5512

Date Returned to/Received by GSS
FOR GSS USE ONLY

I. CLIENT INFORMATION

PATIENT'S NAME	BIRTHDATE	SOCIAL SECURITY NUMBER	MEDICAID NO.
Client # 082506	[redacted]	[redacted]	[redacted]

HOME ADDRESS (No. & Street)	BORO	ZIP CODE	TELEPHONE NO.
[redacted]	[redacted]	[redacted]	[redacted]

Hospital/Clinic Chart No.	Contact Person	Contact Tel. No.
	[redacted]	[redacted]

II. MEDICAL STATUS

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA/ Dept. of Social Services in connection with my request for home care.

DATE: SIGNATURE(X)

How long have you treated the patient? 11/29/79 Date of this examination: 5/27/08 Place of this examination: office Date of next examination:

A. CURRENT CONDITION

DATE OF ONSET		Check (✓) prognosis of each	Anticipated Recovery in 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
	1. PRIMARY DIAGNOSIS	Dementia, arteriosclerosis, macular degeneration			
	2. SECONDARY DIAGNOSIS	Type 2 diabetes, hyperlipidemia			
	3	Arthritis			
	4.	Severe urinary			
	5.	Abdominal mass			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN: (Hospital Name) ADMISSION DATE:

Reason for HOSPITALIZATION: EXPECTED DATE OF DISCHARGE:

C. MEDICATION

		DOSAGE	ORAL or PARENTERAL	FREQUENCY
1.	Zocor	10mg	po	daily
2.	ASA	81mg EC	po	daily
3.	Toprol XL	50mg	po	daily
4.				
5.				
6.				
7.				

INDICATE PATIENT'S ABILITY TO TAKE MEDICATION: (*)

1. ☐ can self-administer
2. ☐ needs reminding
3. ☐ needs supervision
4. ☐ needs help with preparation
5. ☒ needs administration

(*) If patient CANNOT self-administer medication

(a) can he/she be trained to self-administer medication? ☐ Yes ☒ No If No, indicate why not: Has dementia & macular degeneration

(b) What arrangements have been made for the administration of medications? Son is aware

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SSN: [redacted]
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D. IMPAIRMENTS Does the patient have any of the following impairments? ☐ Yes ☐ No
If there is an impairment, indicate by check (✓) type and degree of impairment:

SENSORY IMPAIRMENT	PARTIAL	TOTAL
1. Speech	☐	☐
2. Sight	☐	☑
3. Hearing	☑	☐

MUSCULAR/MOTOR IMPAIRMENT	PARTIAL	TOTAL
1. Dominant hand/arm	☐	☐
2. Other hand/arm	☐	☐
3. Muscular Coordination	☐	☐
Upper Extremities	☐	☐
Lower Extremities	☑	☐

CARDIOVASCULAR/RESPIRATORY IMPAIRMENT	PARTIAL	TOTAL
1. Respiratory function	☐	☐
2. Cardiac function	☑	☐
3. Circulation	☑	☐

ELIMINATION (Check ✓)

	Continent	Occasionally Incontinent	Incontinent
Bladder		✓	
Bowel		✓	

Indicate reason for incontinence and what is currently being done: _____

E. MENTAL STATUS - Does the patient exhibit any of the following? ☑ Yes ☐ No If Yes, check appropriate boxes.

	Some-times	Always		Some-times	Always		Some-times	Always		Some-times	Always
1. Disoriented to place/time	☑	☐	4. Short-term memory impairment	☐	☑	7. Impaired judgment	☑	☐	10. Communication problems	☐	☐
2. Anxiety	☑	☐	5. Wandering	☐	☐	8. Danger to others	☑	☐	11. Sleep Disorder	☐	☐
3. Agitation	☑	☐	6. Depression	☑	☐	9. Danger to self	☑	☐	12. Abusive	☐	☐

Describe the nature, frequency and effect on client's functioning for any area checked.
Attach additional documentation if necessary.
Has had poor memory & disorientation. Has dementia & macular degeneration. As such can be danger to herself

Is patient alert? ☑ Always ☐ Sometimes ☐ Never

Can patient direct a home care worker? ☐ Yes ☑ No If No, explain below. Patient has dementia

F. MEDICAL TREATMENT Does the patient need any of the following medical treatment? ☐ Yes ☑ No
Indicate medical treatment needed: (✓)

1. Decubitus Care		7. Colostomy care		15. Suctioning	
2. Dressings: Sterile		8. Ostomy care		16. Speech/hearing therapy	
Simple		9. Oxygen administration		17. Occupational therapy	
3. Bed bound care (turning, exercising, positioning)		10. Catheter care		18. Rehabilitation therapy	
4. Ambulation exercise		11. Tube irrigation		19. Indicate any special dietary needs	
5. ROM/Therapeutic exercise		12. Monitor vital signs			
6. Enema		13. Tube feeding		20. Other	
		14. Inhalation therapy			

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

SSN: [redacted]
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G. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered
Cane			
Crutches			
Walker	✓		
Wheelchair	✓		
Hospital Bed			
Side Rails			

	Has	Needs	Ordered
Bedpan/Urinal			
Commode	✓		
Diapers	✓		
Hoyer Lift			
Dressings			
Respiratory Aids			

	Has	Needs	Ordered
Bath Bar			
Bath Seat			
Grab Bar			
Shower Handle			
Other (Specify)			

If any needed equipment was not ordered, what other plans have been made to meet this need?

III. IDENTIFICATION OF SERVICE NEEDS

A. Indicate ability to ambulate/transfer:

	Can	Cannot	Can with assistance of:				
			Cane	Walker	Person	Other:	(Specify)
1. Ambulate inside					✓		
2. Ambulate outside					✓		
3. Get up from seated position					✓		
4. Get up from bed					✓		
5. Transfer to commode					✓		
6. Transfer to wheelchair					✓		

B. Indicate any services needed (✓)

A. CHORE SERVICES:

- ✓ Cleaning
- ✓ Meal Prep
- ✓ Laundry
- ☐ Shopping
- ☐ Reheat Meals

B. PERSONAL CARE SERVICES:

	Partial	Total
1. Grooming	☐	✓
2. Dressing	☐	✓
3. Washing	☐	✓
4. Bathing	☐	✓
5. Feeding	☐	✓
6. Toileting: Bedpan	☐	☐
Commode	☐	✓
7. Other special toilet needs:		

IV. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? ☐ Yes * ☐ No

* Identify AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

PHYSICIAN'S CERTIFICATION

I, the undersigned physician, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and that I may be contacted for further clarification.

ROBERT MANN — (PRINT) Physician's Name
INTERNAL MEDICINE — Specialty
[signature] — Physician's Signature
☐ Intern ☐ Resident

5/27/08 — Date Form Completed
116720 — Registry No.
718-435-6555 — Telephone No.
Hospital Contact Person
Telephone No.

Indicate where form was completed:

Hospital/Clinic/Inst. Name
Address
Telephone No.

If nurse/social worker/other person assisted in completing this form:

Name
Title
Address
Telephone No.

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